October 25, 2004

David Martinez
TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1609

MDR Tracking #: M2-05-0138-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Orthopedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The medical records suggest that the patient had onset of low back pain performing his normal job activities. It is unclear how long the patient had been on the job, however, conservative care was unsuccessful, and the patient underwent spinal arthrodesis from an anterior approach by orthopedic surgeon ___. In review of the medical records; however, an MRI from near the injury date revealed that it was a normal MRI, except for a small protrusion measuring 2 mm – 3 mm effacing the sac only which was suggestive of a unremarkable MRI. Surgery was performed according to the operative report on 6/09/03, apparently on the basis of a positive discogram. In review of the discogram that was performed in May of 2003, it was invalid by today's standard in as far as a single level discography, and although a disc protrusion was verified by the discogram, the body of the report stated that there was no pain provocation. It is unclear in retrospect the indication for a single level spinal arthrodesis for discogenic back pain if the provocative discography in itself did not reproduce the presenting complaint. Nevertheless, the patient underwent the surgery and continues to have back pain, and has been through a variety of care under multiple physicians. Most recently, he had been evaluated by a surgeon, ___, who recommended no further surgery on the basis of an EMG showing no acute radiculopathy. It is suggestive on follow-up diagnostics, that the arthrodesis is stable without complication. There is no mention of residual or new onset of active radiculopathy and no mention of spinal instability.

REQUESTED SERVICE

Lumbar decompression fusion instrumentation L5-S1 level is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The basis for this decision is the following: The patient had back surgery for back pain on the basis of a positive discography. However, the discogram was negative for pain provocation. The original MRI post injury shows a mild central protrusion and it does not appear that the patient has benefited from this spinal surgery. A peer review physician and a second examining spinal surgeon did not recommend repeat surgery. The literature in regard to The Lumbar Spine authored by Dr. Harry Herkowitz, evidence based medicine Cochran's Collaboration by Gibson-Waddell; Canada studies as published by published by Analgesia 2001, Volume 5, no. 1 regarding revision of spine surgery; and general principles that revision of spine surgery should be carefully tailored toward those individuals who have failed back surgery with clear evidence of spinal instability or nerve root compression. Revision of spine surgery for treatment of back pain alone is highly unpredictable and often un-satisfactory. On the basis of unsuccessful surgery to date and opinions that further surgery is not medically necessary with no report of complication of current instrumentation or the development of spinal instability or active nerve root compression, the medical necessity for elective revision spinal surgery cannot be confirmed in this independent review.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings

within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 25th day of October, 2004.